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A Business Plan for the IHS

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Need for Business Plan

The health care environment in and around the Indian Health Service (IHS) is undergoing unprecedented change. Health care organizations throughout America are changing to accommodate managed care, growing competition, and market shakeouts. Restructuring, merging, and consolidating health care organizations are increasingly common. Although technology and medical practice standards continue to advance, the ability to afford more sophisticated services remains static. Growth in government health care spending, especially in Medicare and Medicaid (M&M), is facing constraints. State health care reforms hold unknown implications for American Indians and Alaska Natives (AI/AN).

Major change is underway within the AI/AN health care system, too. The service population and costs of providing services are rising while the IHS budget appropriations remain flat. Third party collections (funds collected from Medicare, Medicaid, and private insurance) are becoming more critical to supplement the appropriations. Agency resources are being transferred to tribes as they assume health service delivery responsibilities.

Dr. Michael H. Trujillo, Director of the IHS, sees these and other forces continuing to strain the Agency's ability to fulfill its health mission to Indian people. He says the AI/AN health care system must be prepared to perform in a new era of health care delivery. The Indian health system must develop new strategies to assure a successful future in a changing environment. Dr. Trujillo has often observed that unless the Agency and its primary stakeholders undertake necessary changes, others may apply changes without AI/AN priorities as the guiding factor.

One of the Director's strategies is to design a new IHS with participation by the key stakeholders in the AI/AN system. To guide the design process, the Director formed the Indian Health Design Team (IHDT) in 1995. The IHDT is composed of tribal leaders, urban Indian leaders, and IHS employees. The IHDT has proposed more than 50 structural and operational changes to the IHS. These changes will significantly affect internal business operations of the Agency.

Designing a new IHS is a critical starting point, however, fiscal solvency is necessary to allow the elements of a redesigned IHS to succeed in adapting to a new era. An Agency business plan is part of the broad strategy initiated by the Director to meet the financial challenges for fiscal year 1996 and for the years to come. Together with a commitment to culturally sensitive, community oriented care, pragmatic business planning is an essential ingredient to assure that AI/AN health programs are solvent and a valued asset to AI/AN people well into the 21st century.

A workgroup was established to develop a business plan for the Agency. The Business Plan Workgroup's immediate priority is to assure financial solvency for fiscal year 1996. Half of the fiscal year had passed before the Congress finalized the IHS appropriation. The effects of budget restrictions and unfunded costs are cumulative. The business plan must project revenue and cost trends several years into the future and identify short and long range plans to deal with them. The workgroup must be aggressive if the IHS is to balance the books and maintain service continuity throughout the remainder of the year.

In This Issue...

The Business Plan Workgroup

The workgroup is cochaired by Mr. Michel E. Lincoln, Deputy Director, Indian Health Service, and Mr. James T. Martin, Executive Director, United South and Eastern Tribes, Inc. Members include elected tribal leaders, tribal health directors, business managers, accountants, physicians, nurses, federal executives, and private sector consultants. The membership mix reflects the new IHS leadership that practices a broad-based, participative management style. The workgroup benefits from the diverse views of participants from different backgrounds. All members are encouraged to bring forward their views in a spirit of partnership and with a will to work together for all Indian people.

When workgroup members were asked what they wanted the IHS Business Plan to achieve, some of their responses were:

- Identify new practices to enhance revenue.
- Plan how to provide better and faster services at less cost.
- Develop capability to respond readily to changes in the market.
- Preserve quality as well as quantity of health care services.
- Incorporate business-like practices to improve the system.
- Build a unified corporate approach that benefits the IHS, tribes, and urban Indian programs.
- Focus on multi-year time horizon (lead change).
- Aggressively instill managed care practices.

A Four-Track Business Plan

The workgroup has identified four primary issues for the business plan.

- *Revenue Generation.* The business plan will project revenue trends from all sources, identify sources that have additional potential, and design measures to realize those gains.
- *Cost Control.* The plan will quantify and project cost trends, identify factors driving unfunded increases, and pursue measures to control costs and maintain financial solvency.
- *Transfer Tribal Shares.* The plan will quantify tribal shares to be transferred (both under Title III compacts and Title I contracts), set a schedule for completion of transfers (at Headquarters and at each of the Area offices), and identify measures to accomplish the transfers on schedule.
- *Internal Business Improvements.* The plan will identify measures and a timetable for installing additional businesslike practices to improve management and internal Agency operations.

Revenue Generation Priorities

The Business Plan Workgroup endorsed the following as the next steps to raise revenues:

- Raise M&M reimbursement rates.
- Establish Area-specific private insurance fee schedules.
- Institute a new charge master during 1996.
- Establish electronic billing capability at service units.
- Establish a service unit collections plan.
- Develop methods to measure productivity.
- Institute Visa and MasterCard charge billing guidelines.
- Develop guidelines and policies to allow contracting with health maintenance organizations on a prospective basis.

A subgroup of the Business Plan Workgroup is working with the Health Care Financing Administration (HCFA) to increase reimbursement rates for M&M covered patients receiving IHS services (see Table 1). The IHS is asking HCFA for a 50% increase in its reimbursement rates for calendar year 1996 for inpatient and ambulatory services. The increase is

Table 1. Proposed Medicare and Medicaid rate increases for IHS, 1996.

	Location	1995 Rate	1996 Rate	Increase (%)
Medicaid: All inclusive inpatient per diem rate*	Alaska	$570	$930	$360 (63)
	Lower 48	$487	$736	$249 (51)
Medicare and Medicaid outpatient visit rate†	Alaska	$159	$233	$74 (47)
	Lower 48	$95	$147	$52 (55)
Medicare: Part B ancillary rate‡	Alaska	$256	$512	$256 (100)
	Lower 48	$219	$405	$186 (85)

* Medicare inpatient rates vary and are based on Diagnostic Related Groupings (DRGs).
† Excludes surgery; surgery rates vary and are based on rates established for freestanding ambulatory surgery centers.
‡ Estimated to involve a very low workload in IHS (inpatients whose Part A benefits have been exhausted.)

pending approval by the Office of Management and Budget (OMB) and publication in the Federal Register. If approved by the OMB, the higher rates would increase revenue to the IHS by about $65 million annually, and about $40 million for the balance of fiscal year (FY) 1996.

The increase and continuation of the new reimbursement rates are contingent on the Agency's ability to convince HCFA that the IHS cost estimates are valid for the short term and that the Agency is committed to developing the capacity to meet M&M cost reporting requirements in the long term.

To meet the HCFA cost reporting requirements, a new cost reporting system would have to be implemented involving a substantial initial investment that is not currently budgeted. Given the clear payoff from higher reimbursement rates, one solution would be to invest a small percentage of any increased M&M revenues to implement a new cost reporting system.

Cost Control Priorities and Improved Business Practices

Another subgroup of the Business Plan Workgroup is developing a variety of measures to control costs and improve internal business practices. The subgroup has made 17 proposals. Not all the measures will be fully implemented, depending on the degree of restrictions necessary to maintain financial solvency. The proposals are as follows:

- Centralize personnel transactions.
- Further develop and utilize prime vendor sources.
- Improve control over contract health services (CHS) obligations.
- Establish a one-rate payment policy for CHS providers for the IHS.
- Establish a rate quotation policy for CHS.
- Limit total expenditures for employee bonuses, with reward preferences for those providing direct care and those achieving cost savings and revenue increases.
- Freeze assessments by the Department of Health and Human Services at current levels and identify means to reduce Agency costs paid through assessments.
- Impose hiring controls and restrictions (Areas and Headquarters).
- Increase the number and use of inter-agency agreements with the Veterans Administration and the Department of Defense.
- Limit overtime (Areas and Headquarters).
- Review and consider freezing of non-638 contracts and grants.
- Impose additional travel restrictions.
- Restructure the budget.
- Expedite budget allocations to the field.
- Improve cost accounting (see revenue generation).
- Market prudent business practices to employees.
- Reduce accounting transactions.

In October 1995, the Business Plan Workgroup estimated that IHS and tribal contracts and compacts would experience $92 million in increased costs that were not funded in the FY 1996 IHS appropriation. The majority of the cost increases are the result of inflation and higher salary rates.

The Business Plan Workgroup considered an analysis of IHS financial solvency during its May meeting that updated the forecasts made in October 1995. The new projections include the final budget from Congress and savings resulting from earlier spending restrictions applied during continuing resolutions. The new estimates are as follows:

- The Congress added $22.5 million to partially offset increased costs due to inflation in compensation for health professionals and providers.
- The workgroup estimates $6-7 million was saved from the FY 1996 IHS payroll costs due to the decrease of 153 FTEs since the beginning of the current FY.
- Patient referrals under CHS were further restricted because costs of inflation ($16 million) were not appropriated. Six million dollars in new retirement system costs did not occur in FY 1996 as originally forecasted.
- Buying restrictions and expanded use of prime vendor sources resulted in $2 to $3 million in decreased costs on supplies and materials.
- Funding for Indian Self-Determination contracts and compacts were extended at previous amounts because costs of inflation ($31 million) were not appropriated.

The workgroup concludes that the IHS will balance financially for FY 1996. A combination of new income and steps to limit spending appears to be working in the aggregate for Agency solvency. However, many local managers must continue to work to balance their local budgets because the revenues gains and cost savings experienced by each site will be different. For instance, increased appropriations offset increased payroll costs only for health professionals, not for the entire workforce. Increased M&M collections will be realized in varying amounts at service units and by tribal contractors, but not by Headquarters and Area Offices.

While the financial restrictions appear to have been successful from a solvency perspective, the overall buying power for programs has eroded. Many programs have had to economize by limiting replacement of employees, reducing purchases of supplies and services, restricting patient referrals under CHS, and by freezing contracts at FY 1995 levels.

Tribal Shares Issues

The law authorizing transfer of federal programs and resources to tribes under Title III Self-Governance compacts or Title I contracts was not intended to create new unfunded financial obligations for the IHS. Rather, upon tribal request, the law transfers existing IHS resources from federal control to tribal control. The law also grants substantial flexibility to

tribes to reconfigure their health programs. Resources can be flexibly reallocated among health services to better achieve local community priorities and needs.

The law allows tribes to collect reasonable support costs for providing direct patient services. Such costs are typically 25% of the direct service budgets. The business plan will identify tribal share resource transfers and report an estimate of unfunded support costs to Congress.

The pace of financial transfers is a significant business planning issue. Without careful planning, abrupt, large scale resource transfers from Areas and Headquarters can disrupt the support services for other tribes that are not a party to the compacts or contracts. Additionally, there are one-time costs to convert non-cash assets (especially fixed staff) to dollars for transfer.

The Business Plan Workgroup proposes the Agency set a time frame to accomplish transfer of resources to tribes that request shares of Headquarters and Area Office resources. The proposal would assure tribes of a timetable for receiving resources and allow sufficient time for Areas and Headquarters to redesign programs and transfer these resources. The proposed timetable (24-30 months is one possibility) and percentage transfer for each period will soon be completed by the workgroup. A model was developed to forecast tribal shares through 1999. The forecasts, combined with phasing in the transfers, should allow IHS Headquarters and Area offices to anticipate transfers to plan for a smooth transition.

Model Business Plan for the Future

The majority of the workgroup's business planning has focused on relatively short range financial solvency issues. Typical business plans have a more strategic, long-range focus. The workgroup has charged a subgroup to assess potential business plan models focusing on broader strategies to apply 2 to 5 years into the future.

The IHS, tribal health programs, urban Indian programs, and private sector components are increasingly prevalent in a hybrid mix that should be viewed as an Indian health system (as distinguished from the Federal IHS Agency). An IHS business plan will reflect this mix. Elements of private sector business plans that address market share, product mix, competitive status, sales and revenue targets, and marketing strategy will be adapted. The long range IHS Business Plan may incorporate elements found in the strategic plans of public sector and nonprofit institutions. Finally, the IHS Business Plan must include components that respect the unique Federal responsibility to American Indians and Alaska Natives and government to government relations with sovereign tribal nations. ®

Go Where the Money Is

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Willy Sutton was a bank robber. When asked why he robbed banks, he replied, "Because that's where the money is." Sutton's Law is familiar to medical students who learn early in their training to focus on diagnostic and treatment endeavors that maximize the likelihood of fruitful results, i.e., go where the money is. At the risk of being too literal, Sutton's advice is very timely for the Indian Health Service (IHS) as we face decreasing federal funding.

During the past five years, funding for IHS hospitals and clinics has been level or decreasing in real dollars, except in service units with new facilities. While the population has increased through births and increased longevity, there has been no recognition of these increases in the budget. The result is a squeeze where we are struggling to provide services to more people with better and more expensive technologies, but have fewer resources to accomplish our goals. IHS leadership has responded by developing a business plan (see article starting on page 73) that Dr. Trujillo has said will be the mainstay of many of our programs, because if the Agency is not solvent, we will no longer exist. A major element of the

Business Plan is the generation of increased revenues from third-party sources, including Medicare, Medicaid, and private insurance. While Headquarters has been successful in negotiating with the Health Care Financing Administration for increased reimbursement rates from Medicare and Medicaid, increasing private insurance revenue is almost completely dependent on local providers and managers adapting more aggressive billing practices at each location.

Because of the uncertainty of the federal budget process this year, it has been very difficult to develop local budgets. This uncertainty demonstrates to many of us in the field that we must improve our ability to accurately register patients with third party payers, and bill and collect whenever possible. While we will continue to rely mostly on direct federal money, we can no longer ignore collectible private insurance. With Medicare and Medicaid, itemization of services is not required, and we are reimbursed at a flat rate regardless of the diagnosis; complexity of care; or costs of drugs, laboratory tests, or procedures performed. Therefore, to increase collections, we need to develop an itemized method to charge insurance companies, much like fee for service, private sector organizations.

A major problem, which hindered the IHS from collecting more from insurance companies until recently, is the fact that we mistakenly used a centralized fee system. This resulted in our fees for supplies, services, and procedures lagging behind local rates. Headquarters has served notice that the authority to set fees is now the responsibility of local management, which is expected to have rates competitive with the private sector. The longer local managers wait to update the fee schedule, the longer it will take to collect fair market rates. Numerous firms evaluate fee schedules to establish rates based on the amounts insurance companies are paying by geographic location. Statewide hospital rate reviewing organizations are also resources available to help establish locally competitive rates. Since rates change frequently, this activity will require periodic attention by managers to keep current.

Several service units have now created "superbills," itemized charge sheets (see Figure 1) that facilitate quick and accurate billing by the business office staff. Not having a charge sheet results in the Business Office staff having to use the medical record to gather the necessary information to develop a bill. This is an extremely inefficient way to operate, as the Business Office staff are often not experienced in chart reviews, which leads to missed charges and longer processing time. The billing form is very familiar to those of you who have worked in the private sector, and usually consists of the following items:

- **Cognitive services.** Fees for outpatient visits are based on the duration and complexity of the encounter, with higher fees billed for new patients and those patients requiring complex care. Team conferences, some patient education services, and case management services are also billable.
- **Procedures.** Procedures are reimbursed at higher rates than cognitive services, accounting for a disparity in reimbursement between specialties.
- **Nursing activities.** Injections, immunizations, dressing changes, intravenous line placement, and many other nursing activities and procedures are reimbursable.
- **Imaging, laboratory, and pharmacy.** By itemizing X-ray, ultrasound, laboratory, and drug charges on a superbill, fair reimbursement can be obtained for complex case services that now are being provided below costs. As the Resource and Patient Management System (RPMS) lab and X-ray packages spread throughout the system, this activity should become easier to automate, like the pharmacy system is now.

Each department, specialty clinic, and inpatient unit should develop appropriate charge sheets specifically addressing the services typically provided. Policies and procedures need to be implemented to get medical records or appointments staff, or possibly triage nurses, to insert the proper billing slip into the charts of insured patients so the practitioner will be signaled to complete the form. Once clinical staff have worked with the charge sheet, it is quite easy to use and can be readily converted to a bill by the business office. Ironically, the IHS has been paying itemized bills through Contract Care to many providers for years, but we have only recently begun to itemize our own charges. In effect, we have been undercharging insurance companies which, of course, has been to their advantage. Instead of decreasing their premiums to Indian subscribers, they have made profits from our naivete. It is certainly time for us to collect fair and reasonable fees for services provided to patients who have insurance.

In some facilities, we do not charge for anesthesia, physical therapy, and other routine services. Charge systems that capture supplies and patient care need to be developed to allow itemized billing for inpatients. These systems are commonly available. Contact a local hospital to identify a vendor. Dr. Philo Calhoun at the Santa Fe Service Unit is using bar code systems to capture supplies and services in the operating room. (An article on this topic will appear in an upcoming issue of *The IHS Provider.)* The Pine Ridge Service Unit is moving aggressively to implement a bar code-based charge capturing system. The IHS Billings Area hospitals have ordered a system that will include the use of bar code scanners with the more common sticker labels. The cost of these charge systems is very low, and the potential payoff very large.

As private insurance is increasingly provided by Health Maintenance Organizations (HMOs) rather than traditional indemnity policies, individuals and employers in our service areas are using this less expensive form of insurance. It is unlikely that you will be reimbursed by an HMO for primary care services. In heavily penetrated markets like Albuquerque, this has made it increasingly difficult to collect private insur-

Figure 1. Example of a “Superbill.”

ance money. The HMOs have a scandalously good deal going. Individuals and employers pay them premiums for health insurance that covers primary care service, among other benefits. Indian subscribers may continue to use IHS-funded facilities for their care instead of the HMO network providers, costing the HMO nothing. This is akin to a federal subsidy, since the HMO can collect premiums without paying IHS for reimbursable services. Some patients continue to use the IHS because of established provider relationships, and some merely to avoid a copay. Some just use IHS pharmacies to avoid drug costs. The effect is the same though: employers and employees are improving the balance sheets of HMOs at a cost to the taxpayer and the federal government.

In order to deal with the non-reimbursement issue, it is important to talk to tribal leaders and Indian employers so that they can select insurers who will reimburse IHS directly. If HMOs are clearly the top choice, then we need to negotiate to be part of their network of providers so that we can collect for primary care visits and other services. Providers are required to hold a current license in the state where services are being provided, and the usual credentialling process is required, but there seems to be no legal or industry-wide prohibition against including government practices in HMO provider networks. A recent legal opinion in the IHS Portland Area argues that legislation authorizing IHS to collect private insurance also obligates managed care firms to reimburse IHS. We encourage you to discuss the HMO issue with your administration and directly with your local HMOs.

No one can predict the direction of congressional priorities or the outcome of the next presidential election, but the following quote from Dr. Trujillo certainly rings true today. "For tribal, urban Indian, and Indian Health Service programs, collections from third party payers like Medicaid, Medicare, and private insurance programs will be the only new revenue sources for our programs." The Third Party Collections Workgroup encourages you all to maximize third party resources due to your service units because in Willy Sutton's words, that's where the money is. ®

NCME VIDEOTAPES AVAILABLE ®

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in the The IHS Provider *on a regular basis.*

NCME #694

Bicycle-Related Head Injuries: The Physician's Role in Prevention and Management (30 minutes) Approximately 1,000 people in the United States die from injuries caused by bicycle crashes each year. In addition, more than 550,000 Americans are treated in emergency departments for injuries related to bicycle riding. Dr. Fred Rivara examines the magnitude and extent of bicycle-related head injuries and the potential effect of increased helmet use. Ms. Lisa Rogers demonstrates how to form and evaluate bicycle helmet programs, and emphasizes the role physicians can play in increasing the use of helmets in their communities.

Gene Therapy for Inherited Diseases of Metabolism (10 minutes) Research has turned to gene therapy as the next frontier for the treatment of many genetic diseases caused by enzyme deficiencies. Using Gaucher Disease as a model, Dr. John A. Barringer explores the major questions related to all approaches to human disease using gene therapy: Is gene transfer and its expression likely to change the phenotype? Will the transgene be expressed sufficiently well and for a long enough time so that the disease will be reversed? And, finally, can these steps be accomplished safely?

NCME #695

Postmenopausal Hormone Therapy: Weighing the Benefits and Risks (60 minutes) Although there is increasing evidence that postmenopausal estrogen therapy has a beneficial impact on cardiovascular disease and osteoporosis, many women are concerned about potentially increased risk of breast cancer with hormone treatment. In this program, Dr. Leon Speroff offers a rational approach to this therapeutic perplexity, and offers suggestions for patient counseling.

NCME #696

Obstetric Ultrasound in Primary Care: An Example of Technology Transfer (60 minutes) Diagnostic ultrasound is an invaluable tool in the evaluation of pregnancy. Dr. William MacMillon Rodney believes this technology should be readily available to the obstetrics-capable primary care physician. In this telecourse, Dr. Rodney outlines the benefits to the patient, discusses training and competency issues, and demonstrates diagnostic ultrasound technique.

Managing Change and Marketing Public Health in the IHS

Because Tomorrow Matters

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> In times of change, the learners inherit the earth while the learned find themselves beautifully equipped to deal with a world that no longer exists.
>
> Eric Hoffer

Background

As the Indian Health Service (IHS) approaches the next millennium, it is faced with the most profound changes in its history. It must simultaneously deal with political and fiscal pressure to downsize its administrative infrastructure, turn control and resources over to tribes exercising their right of self-determination, and reinvent itself through the directives of the Reinventing Government Initiative and the National Performance Review.

Any one of these forces alone would warrant serious consideration for some type of reorganization, but collectively they create an absolute mandate for significant change. The opening words of Eric Hoffer should be considered as we ask ourselves: Are we, in IHS health programs, managing this change appropriately? Are we, as a comprehensive public health program, consistently emphasizing what is most important, what should be changed, and what should be preserved during this transition, and in a compelling way that can be heard and believed by tribes?

I am convinced we could be doing better relative to both of these issues, and that it is not too late to make these improvements. Thus, this article represents my attempt to focus on problems and opportunities that relate to all of us who work in health programs. While serving almost 23 years in the IHS has undoubtedly contributed to what insights I might have, two recent experiences have forced me to "think outside the box." The first was serving as a reviewer of Tribal Self-Governance planning grants and then as a Self-Governance negotiator in 1994. The second was performing the literature review on reorganization and public health for the Indian Health Design Team (IHDT), and later, service as a member of the IHDT's Clinical and Public Health Workgroup. Both of these experiences renewed a personal interest I have long had for real-world learning about organizational development, planned change, and the nature of resistance to these forces. Indeed, the IHS has become quite a laboratory for these topics.

Models to Help Us Understand Ourselves and Embrace Change

While there are many authors and conceptual models of organizations and change to which to refer when exploring the dynamics of our current situation, two seem particularly useful in helping us understand where we are and where we need to go. The first is the work of William Bridges[1] on managing transitions, and the second is Peter Senge's[2] perspective on the "learning organization." Both works are based on some simple, basic assumptions. First, change has been and always will be a part of organizational life, but it now appears to be accelerating. Second, an organization's success in business and managing change is largely determined by the strategic soundness of its work plan in terms of the organization's mission and its interface with the external environment (i.e., customers, competitors, and society at large), and how well the plan is implemented by the people who do the work. It should not require a large leap of faith to agree that poorly thought out plans, even when well executed, usually fail, as do very good plans poorly carried out.

Bridges' model, as outlined in *Managing Transitions: Making the Most of Change*,[1] does not directly address the appropriateness or rationality of a change initiative, but is an approach to facilitate employees' acceptance of, commitment to, and follow-through with a change plan. Bridges contends that many reorganization efforts fail when they do not address the inherent emotional resistance that people have to any change. He describes three phases of change: the ending, the neutral zone, and the new beginning, and how to facilitate movement through each. I recommend that anyone feeling the tension of pending changes read this book for themselves and their program. It is concise and written in a very down-to-earth style that is both entertaining and powerfully real. I and three other IHS staff have been trained by Dr. Bridges in the

use of this model and have used it with several groups who have consistently reported that it was useful. As the reorganization of the IHS continues, this approach should be made available to all interested groups.

From a broader perspective, Peter Senge's seminal book *The Fifth Discipline: The Art and Practice of the Learning Organization*,[2] integrates management and larger systems theories in a very compelling way, and addresses both the strategic appropriateness and staff "buy-in" considerations of managing change and achieving success. While it is impossible to do justice to Senge's work in a few words, several points and concepts are worth considering in assessing the IHS. A learning organization is one where individuals, and the groups that function within, are committed to life-long learning. Such learning includes self-knowledge and personal mastery; shared knowledge and visions, and synergistic work teams; and awareness of larger systems within an organization, and its interface with its customers and the larger environment. This more global ability to learn has been identified by many current management experts and successful corporate leaders as the only sustainable way to succeed in an environment characterized by rapid social and technological change and global competition. Indeed, the IHS is increasingly facing many of these dynamics. Senge contends that the era of organizations being able to succeed by having a few visionary leaders has past. He offers:

> The organizations that will truly excel in the future will be the organizations that discover how to tap people's commitment and capacity to learn at all levels in an organization.

Senge outlines a series of organizational flaws that he describes as "organizational learning disabilities." These disabilities represent prevalent behavior patterns that cripple an organization's ability to respond positively to a changing environment. Three of these seem to have particular relevance to the current situation in the IHS. The first disability is the collective belief in organizations that "I am my position." By framing ourselves largely by what we normally do in the organization (e.g., I'm a dentist, I deal with dental health), we tend to see our responsibilities as limited to the boundaries of our position. By breaking health care up into many little pieces and focusing only on them, we have little sense of responsibility for the results produced when all the pieces come together (e.g., when consumers access our system). If the results don't come out very well, and they often don t, we are often at a loss as to why, and assume "someone else screwed up." But the problem is actually our own "tunnel vision" and inability to perceive the larger systems that are functioning.

If we are to succeed as the "new IHS," it seems clear we must lower walls and build bridges across health disciplines at all levels, and particularly with communities and tribes; the Director and the IHDT have advocated for this. However, the literature has shown that developing this kind of synergy to make the entire system work better has been particularly challenging for health care systems. Nevertheless, it is critical that we strive to build such collaborative and synergistic teams at all levels of Indian health care systems. It is not only a better way to coordinate programs and services, it is a necessity, given that we no longer have a full complement of all the health disciplines in many settings.

A second organizational learning disability Senge describes as the "parable of the boiling frog." It is based on the notion that organizations actually have more difficulty responding to pressure for slow gradual change than threats from rapid change. If you take a frog and set it into a pan of hot water it will instantly sense the thermal threat and scramble to get out. However, if you place the same frog in a pan of cool water without scaring it, and gradually heat the water, it will sit there calmly until it gets so groggy from the heat that it can't respond to the impending danger, and the water will eventually kill the frog as it approaches boiling (skeptics, please trust this experiment and don't replicate it). The frog's physiology is only responsive to sudden changes in its environment. From a corporate perspective, the US auto industry displayed a similar response (or lack thereof) to the growing influx of small imported cars from the mid-1960s into the 1980s.

A case could be made that the IHS has responded somewhat like the frog and the auto industry since the Indian Self-Determination and Education Assistance Act was passed in 1975. The message was clear; tribes would be assuming responsibility for health care in the future, but the need to adapt to this change seemed minimal in 1975. Furthermore, the liabilities accepted by not responding more proactively to the gradual changes occurring did not seem great during the first 15 years. However, the pace has picked up so much over the past five years that we are now struggling to adapt as the water is warming up. I don't believe there has been a conscious effort not to respond to these changes or not to facilitate self-determination. It's simply that most of us have been trained to deal with health problems rather than community empowerment, and we have had plenty to do just dealing with the overwhelming health care needs of the growing American Indian/Alaska Native (AI/AN) population. But if we had been less "frog-like" over the past 20 years we would have put more effort towards developing local capacity and building more shared partnerships with tribes, and the transition we are struggling with now would probably be more seamless.

The last learning disability that I think we should consider in the IHS is the prevalent belief that the "enemy is out there." This common behavioral syndrome is simply the excessive tendency to find someone or something outside ourselves to blame for whatever is going on that we don't like. This is usually caused by failing to see the nature of the systems functioning within organizations and at the interface with the environment. This pattern is also closely related to

the "I am my position" disability in that we fail to see how our actions extend beyond the boundaries of our position. When these actions have consequences that come back to hurt us, we perceive them as new problems that are externally caused. The target of blame can be within the organization (such as when service units blame Area offices, or Area offices blame Headquarters, or administrative people blame program people and vice versa) or outside of the organization (such as when the IHS blames tribes or tribal lawyers, or Congress, and back and forth). The utility of this approach is obvious: by defining the source of the problem "out there," we externalize the blame and rid ourselves of the burden of change. But this approach wastes energy and drains morale, and little gets accomplished that is positive. It is a classic "lose/lose" paradigm for all involved.

An alternative perspective is to carefully reflect on the larger systems we may be influencing and try to understand how our behavior may be having a ripple effect, coming back in ways we don't like. In this light, what have we done to stimulate resentment from tribes, from Congress, or from consumers? Have people perceived us as playing control games? Have we promised more than we can deliver, or not adequately followed up on issues others thought were important? Have we adequately communicated or collaborated with people or explained the reasons for the decisions we have made, and have we consistently listened to our consumers adequately? Over the long haul, the adage that you usually get back what you put out, rings true. While I don't think we have done a bad job in these areas, I do believe we have made mistakes and could have done better. While we don't need to beat ourselves up about these deficiencies, we do need to be aware of them to avoid them in the future, and move away from looking for an external enemy.

A final point worth noting about Senge's views of the learning organization and systems thinking is that it isn't really new. It is simply a modernized synthesis of what has been a paradigm of many AI/AN cultures for centuries, and Senge acknowledges this. The sage words of Chief Seattle echo this timeless theme:

> Humankind has not woven the web of life. We are but one thread within it. What ever we do to the web, we do to ourselves. All things are bound together. All things connect.

From Learning to Marketing

In conjunction with managing our transition and learning as an organization, it is critical that we respond more effectively to the dynamics we have already helped create. During this time of rapid transformation of the IHS to an increasingly tribally-managed health care system, there has been a growing awareness that many of the successful Area and Headquarters programs have not adequately marketed their services to tribes taking over health programs. I say that the marketing has been inadequate, not necessarily because the tribes have elected to take their shares of IHS programs, but because they may have often taken them with less than complete and clear information about what they are getting from the IHS for the money, compared to what they can buy elsewhere, or do for themselves. In essence this represents less than fully informed decision making, and many who have participated in or observed Title III negotiations would probably agree with this contention. I can personally attest that trying to market public health at the negotiations table, particularly if you are dealing with lawyers and accountants, is difficult. It is the wrong target audience and much too late in the process, because the decisions have already been made in most cases. In retrospect, I imagine my futile attempts to market public health during negotiations probably seemed self-serving to tribes. Clearly our lack of effective marketing long before we enter negotiations is but one of several factors contributing to this lack of fully informed decision making, but it is probably the major factor over which we can exert significant control.

A growing concern I have, and have heard from others, is that the IHS infrastructure at Areas and Headquarters is rapidly diminishing (i.e., through the payment of tribal shares) despite a history of significant accomplishments in the health of AI/ANs. If these programs continue to be reduced and a critical mass of organizational memory is lost, there may be little left for tribes to come back to, should they decide to "buy-back" the IHS services. Senge warns of the limits of how far you can break things into pieces. At some point it is like cutting an elephant in half: you don't get two small elephants, just one dead one. Stated in terms of our programs, if this current pattern continues, by the time tribes realize we really had something valuable to offer, we might not have it any more. The 1988 report of the Institute of Medicine, *The Future of Public Health*,[3] points out that the loss of public health infrastructure is a large determinant of the relatively poor public health record in America in recent years. Furthermore, it appears that the problem is even greater in smaller community settings with populations of less than 50,000, which represents the vast majority of AI/AN communities. Without intention, we appear to be modeling some of what the report warned of.

Therefore, there is reason for concern, given the loss of buying power of the IHS budget, the loss of economies of scale with the decentralization of AI/AN health resources, and the small amount of residual funding IHS will have if all tribes take their shares through contracting and compacting. Furthermore, the most recent edition of *Trends in Indian Health*[4] reveals that many of the most extreme health problems continue to exist in IHS direct-care populations, and many are not improving. How are we going to address this situation with a rapidly eroding infrastructure? Will we even have reliable and comparable data to know how well programs are working and where the greatest needs are?

It could be argued that some of this loss of infrastructure

is an inevitable outcome of the success of self-determination. But to the extent that it is occurring with so little dialogue about health issues suggests other factors are at play. I contend much can be attributed to two factors that we can address. The first, as discussed earlier, is our image with tribes as being controlling and bureaucratic. The second is that much of the public health infrastructure is relatively opaque to users, and we have not effectively marketed the tangible benefits of what we do. If this pattern continues, it may compromise our ability to advocate for Indian health and, of greatest importance, compromise the realization of the IHS, tribal, and urban Indian programs (I/T/Us) goals and health objectives. I believe we are ethically obliged to do what we can to assure that "the baby isn't thrown out with the bath water."

As stated above, my belief is that part of the rapid tribal pull-out can and should be ameliorated, and perhaps recovered, by more effective and honest marketing of what a public health infrastructure has to offer, and by working to change our image. It appears that many of our programs that are efficient and effective in providing services to local Indian health programs are much less effective in marketing these to tribes. On the other hand, there appear to be a significant number of private firms that are more successful in marketing their services than in effectively performing them in Indian health settings. Many of us have first hand knowledge of how little we can sometimes get for our money from private contractors. Thus, if IHS programs "under market" what they have to offer while some private firms "over market," it is likely that neither the tribes nor the IHS will be well served. I don't think it is self-serving to suggest that tribes will have the greatest chance to improve their peoples' health when they have all the information they need to select or import the best of what the IHS has learned and accomplished, as well tap their own creativity and other sources as well.

Expanding and Modifying a Social Marketing Training Event

In 1991, I became interested in the social marketing work of Richard Manoff, which is well described in his 1985 book, *Social Marketing: New Imperative for Public Health.*[5] As a test of the applicability of Manoff's approach in the IHS, I developed and presented a half-day training session on applications of social marketing methods for the dental program's prevention coordinators. The response from this group was very positive, and as a result I expanded the training to a 3½ day course (The Social Marketing of Public Health Programs), which I presented with assistance from several other social-science professionals starting in 1992 and continuing through 1995. The course was built around a basic definition of social marketing and its application to public health, which is:

> Social marketing is the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s). It utilizes concepts of market segmentation, consumer research, idea configuration, communications, facilitation, incentives, and exchange theory to maximize target group response.[5]

or stated more concisely in the context of public health:

> Social marketing is a strategy for translating scientific findings about health and nutrition into education and action programs adopted from commercial marketing methods.[5]

The only difference between marketing and social marketing is in the objective, not the methods. Social marketing is directly competitive with commercial health care marketing in that it attempts to reduce the market for curative services. While marketing is generally associated with the field of business/management, it was actually derived from social psychology, sociology, anthropology, and communications theory. Thus, both marketing and social marketing are a new synthesis of these elements, wedded to the use of modern mass media. The preeminent premise for both is that the consumer is key, and consumer perception is the fundamental wisdom we must gain. Stated another way, in marketing, perception is reality and the primary focus is to first understand perception and then attempt to alter it. Social marketers typically:

1. Assess the perceptions and practices of the target market.
2. Develop strategies to change behaviors and attitudes of the target market.
3. Aim to serve the interests of the target market or group without personal profit.
4. Market ideas and strategies rather than products or services.

The first two elements are common to both regular marketing and social marketing, while the second two represent the unique characteristics of social marketing. From this perspective, I contend that social marketing is an ethical, systematic, and potentially effective approach to communicating with tribes about what a public health infrastructure has to offer them. The message should emphasize public health rather than the IHS (i.e., if you don't get public health help from us, get it from some other competent source). Beware also that if we are perceived as mostly marketing to keep our jobs, rather than promoting public health, the effort is likely to backfire on us.

The successful application of social marketing technology will require a significant paradigm shift from the controlling and directing approach, which has been prevalent for much of our history, towards a more entrepreneurial perspective in partnership with tribes. Such a transformation has already been advocated by Dr. Trujillo, the IHDT, and much of the literature on reinventing government, but we appear to

have a ways to go before it will be evident to tribes. The application of social marketing demands such a transformation and could perhaps serve to facilitate and accelerate the process.

With the support and sponsorship of the IHS Clinical Support Center (CSC), I am proposing that the previously described course be revised to address the social marketing of public health to local I/T/Us. I propose a 4- to 4½- day course, in Phoenix, between July and September of this year. In addition to social marketing concepts and the corresponding qualitative research methods (e.g., focus groups), this course might also include applications of contextual marketing concepts, self-efficacy/empowerment and community development models, adult learning styles, the learning organization, and other topics consistent with the participant's needs. I am willing to serve as the course coordinator and have several resource people available to help. It may be useful to form a planning committee to better define the needs of participants and perhaps help develop appropriate case studies or simulations. Above all, the course will be for people who are committed to learning and using the learning to market public health for the benefit of the AI/AN people.

Conclusion and Opportunities to Participate

In summary, the reality we face is that if the tribes don't buy the concept that the IHS has valuable services to offer them, parts of us, like the bisected elephant, die. If we sincerely believed it is a timely death, and the tribes will be well served in the long run, I think many of us could accept it as a natural evolution of self-determination. On the other hand, if we examine ourselves and the currently unfolding situation with candor and humility (i.e., learning) and conclude that tribes may suffer in the long run by the impending loss of our public health infrastructure, we have a responsibility to face. I believe this latter case is the truth. Our country has demonstrated quite conclusively that without an adequate public health infrastructure, we can spend a lot on health care and not do much for many of those who need it the most. I suggest there are two things we need to do with a high level of integrity. First, we must continue to make sure that we have a quality product to offer. To do this we must effectively manage our transition and move toward being more of a "learning organization." In some situations, our product could be helping tribes develop the capacity to create their own infrastructure, while in other cases we may be asked to provide services and maintain the infrastructure directly. In either extreme and many situations in between, Peter Drucker's words of wisdom can serve us well:

> Quality in a service or product is not what you put into it. It is what the client or customer gets out of it.

The second thing we can do is to effectively market public health as the valuable product it is and, as part of the process, change our behavior and our image. The course described above is proposed as one approach to this process. I view it as a rallying point for local, Area, and Headquarters program staff to come together, learn some useful public health and marketing skills, develop a shared vision and creative collaborative strategies, and get on with the challenging tasks we face in the new IHS. If my rambling strikes a cord of truth for you and you would like to help plan the course, participate in it, or both, please contact E.Y. Hooper, MD, MPH, or Gigi Holmes, IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, AZ 85016 (phone: 602-640-2140; fax: 602-640-2138). It is a critical time to take a look at ourselves, our programs, and our commitment to public health and self-determination, and to proactively move forward in partnership with all our consumers.

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Call for Papers
8th Annual IHS Research Conference

The Eighth Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (accredited sponsor) will be held August 12-14, 1996 in Albuquerque, New Mexico.

Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research measuring the effectiveness of innovative health care delivery interventions or research that demonstrates partnerships between researchers and tribes is especially welcome.

Abstracts must be received no later than close of business on July 1, 1996 to be considered for review (see "Instructions for Preparing Abstracts" below). Notice of acceptance of abstracts will be mailed by July 19, 1996.

For abstract consultation, contact one of the following Research Conference Planning Committee members: Linda Arviso-Miller at 505-837-4142 or Cherie Thomas at 505-837-4145.

Instructions for Preparing Abstracts

1. Use the abstract form on the next page to prepare your abstract. All copy must fit within the frame. This form may be copied.
2. Accepted abstracts will be reduced and printed in the conference program. Remember that you are producing camera-ready copy. Submit your abstract in a type size no smaller than 12 pitch typewriter type or a 10 cpi font on a word processor. Single space all copies. Do not include figures, tables, equations, mathematical signs or symbols, or references in the abstract.
3. The abstract content should be structured as follows; title, author and affiliation, purpose/background, methods, results, and conclusions. Place an asterisk next to the name of the presenting author. Conclude your abstract with the sentence: "For further information: [Name and address of author serving as point of contact]." The abstract must fit within the frame on a single abstract form and be no more than 250 words in length.
4. Check the desired form of presentation: oral, poster, or either.
5. All abstracts should be sent to: Conference Coordinator, IHS Research Program, 5300 Homestead Road, N.E., Albuquerque, New Mexico 87110 (phone: 505-837-4142). Submit one original signed by the primary author.
6. A biographical sketch must accompany the original abstract. Use the form below. Do not submit a curriculum vitae or resume.
7. Abstracts must be received by close of business July 1, 1996.
8. We will notify authors of the acceptance or rejection of their papers by July 19, 1996.

Any questions about style should be directed to Linda Arviso-Miller, Conference Coordinator, at (505) 837-4142.

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Tobacco Use Prevention
July 8-12, 1996 St. Louis, MO

The Second Annual Tobacco Use Prevention Summer Institute will offer eight courses in tobacco use prevention and reduction: Epidemiology and Evaluation, Tobacco Advertising, Media and Policy Advocacy, Coalition Building, Managing State/Local Programs, Tobacco Pricing, Environmental Tobacco Smoke, and Youth and Tobacco. These courses are designed for new and experienced professionals involved in state and local tobacco control programs, particularly programs designed to prevent tobacco use by youth, and will include background research, theory, and practical experience.

The sponsors are the Center for Health Promotion and Disease Prevention at the University of North Carolina - Chapel Hill and the Prevention Research Center at St. Louis University, in collaboration with the Centers for Disease Control and Prevention's Office on Smoking and Health. For more information, contact Ginger Morgan, Project Manager, University of North Carolina, Center for Health Promotion and Disease Prevention, Tobacco Use Prevention Training Program, Manning Drive, Campus Box #7595, Chapel Hill, NC 27599-7595 (phone: 919-966-5653; fax: 919-966-0973; e-mail: ginger_morgan@unc.edu).

Obstetrical Ultrasound
July 17-19, 1996

This three-day OB/GYN imaging diagnostic ultrasound course is specifically aimed at physicians in practice, first and second year OB/GYN residents, certified nurse midwives, and nurse practitioners who wish to learn and improve their "basic" skills of performing and interpreting anatomic ultrasound examinations. Anyone who has been performing real-time ultrasound procedures for less than 24 months should benefit from participation.

The course includes three half-days of didactic presentation and discussion sessions and three half-days of supervised hands-on practical sessions in small groups. This permits the participants to perfect their skills and put into practice the measurements and calculations discussed in the didactic portion of the course.

This activity is sponsored by the Uniformed Services University of the Health Sciences (USUHS). USUHS designates this activity for 23 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and for 27.6 contact hours of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

For more information, contact LT Tim Osbon, Continuing Health Professional Education, USUHS, 4301 Jones Bridge Road, Bethesda, MD 20814-4799 (phone: 301-295-3106).

Native American Lifesavers Conference
August 12-14, 1996 Denver, CO

The Native American Lifesavers Conference is a unique opportunity for tribes to share their expertise in improving highway safety with other tribes and forge new partnerships with tribal, private, state, and federal organizations to launch an ongoing network for tribal highway safety.

Among other things, the conference will include workshops for law enforcement, judiciary, health and safety practitioners, community advocates, and youth issues; workshops on DUI, occupant protection, community mobilization, resource development, and roadway improvement; and exhibits of successful tribal programs.

The conference is designed to strengthen multi-disciplinary community teams. For more information, contact Lifesavers Conference, Indian Rehabilitation, Inc., 650 North 2nd Avenue, Phoenix, AZ 85003 (phone: 602-254-3247; fax: 602-256-7356).

Overcoming and Preventing Secondary Disabilities in FAS/FAE
September 4-6 Seattle, WA

Secondary disabilities of fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE) are behavioral, medical, or social consequences of the primary disabilities caused by prenatal alcohol exposure. Secondary disabilities may include problems with school, trouble with the law, social and sexual problems, mental health problems, and others. Although the primary disabling conditions of fetal alcohol exposure are long-lasting, many of the secondary disabilities should be preventable. It is vital that these secondary disabilities be understood so that the appropriate prevention and management strategies can be developed and implemented.

This 3-day conference is sponsored by the Fetal Alcoholism and Drug Unit, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, with support from the Disabilities Prevention Program of the Centers for Disease Control and Prevention (CDC), US Public Health Service. Program sessions include: new studies on FAS/FAE; mental health and FAS; FAS and the schools; employment and independent living; FAS, sexuality, and parents; criminal justice and FAS; funding, screening, diagnosis, and services; special issues and programs related to Native Americans; and institutional responses to FAS.

The registration fee for the conference is $70. For more information and registration forms, contact Jonathan Kanter, UW FAS Conference, Fetal Alcohol and Drug Unit, 180 Nickerson Street, Suite 309, Seattle, WA 98109 (phone: 206-543-7155; fax: 206-685-2903; e-mail: jonkan@u.washington.edu).

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THE IHS PRIMARY CARE PROVIDER

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Circulation: *The Provider* (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive *The Provider,* free of charge, send your name, address, professional title, and place of employment to the address listed below.

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Authors should submit at least one hard copy with each electronic copy. Manuscripts may be received via the IHS Banyan electronic mail system. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities/Area Publications Committees to publish manuscripts rests with the author. For those who would like some guidance with manuscripts, a packet entitled "Information for Authors" is available by contacting the CSC at the address below.

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